

Personal Care Service Documentation Log

Student Information

Name: _____ Date of Birth (Mo/Day/Year): _____

Diagnostic Code: _____

Provider Information

Provider Name: _____ Provider Title: _____

Supervisory Union: _____ Name of School: _____

Service Dates: The numbered boxes below reflect the days of the month. **Write the number of hours personal care was provided in the corresponding date box. DO NOT USE PENCIL OR WHITE OUT.**

Month _____ Year _____

Month _____ Year _____

Use this set of dates for a two-month billing period

1	2	3	4	5	6	7		1	2	3	4	5	6	7
8	9	10	11	12	13	14		8	9	10	11	12	13	14
15	16	17	18	19	20	21		15	16	17	18	19	20	21
22	23	24	25	26	27	28		22	23	24	25	26	27	28
29	30	31						29	30	31				
Total hours personal care was provided during the billing period								_____ hours						

If the daily hours provided are consistently different than the time the student is at school, explain:

Service Type: The 1:1 personal care support for this student includes the following activities. Check all that apply (at least one of the 1 through 9 activities must be checked in order to be considered personal care).

- | | | |
|--|--|---|
| 1. <input type="checkbox"/> Assistance w/Eating | 5. <input type="checkbox"/> Behavior Management | 9. <input type="checkbox"/> Assistive Devices |
| 2. <input type="checkbox"/> Assistance w/Toileting | 6. <input type="checkbox"/> Signing/Interpreting | 10. <input type="checkbox"/> Other: _____ |
| 3. <input type="checkbox"/> Assistance w/Dressing | 7. <input type="checkbox"/> Medication Admin. | _____ |
| 4. <input type="checkbox"/> Assistance w/Hygiene | 8. <input type="checkbox"/> Mobility/Safety | _____ |

Provider Signature: _____

Date: _____

Supervisor Signature: _____

Date: _____

Supervisor Name (Printed): _____